

Citation for published version:

Carrick, H & Randle-Phillips, C 2018, 'Solution-focused approaches in the context of people with intellectual disabilities: a critical review', *Journal of Mental Health Research in Intellectual Disabilities*, vol. 11, no. 1, pp. 30-53. <https://doi.org/10.1080/19315864.2017.1390711>

DOI:

[10.1080/19315864.2017.1390711](https://doi.org/10.1080/19315864.2017.1390711)

Publication date:

2018

Document Version

Peer reviewed version

[Link to publication](#)

This is an Accepted Manuscript of an article published by Taylor & Francis in *Journal of Mental Health Research in Intellectual Disabilities* on 31 Oct 2017, available online:
<http://www.tandfonline.com/10.1080/19315864.2017.1390711>.

University of Bath

Alternative formats

If you require this document in an alternative format, please contact:
openaccess@bath.ac.uk

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

Solution-focused approaches in the context of people with intellectual disabilities: A critical review

Abstract

Introduction: Solution-Focused Brief Therapy (SFBT) has a growing evidence base and several authors have recognised the advantages of applying this approach with people with intellectual disabilities (ID). The purpose of this review is to summarise and critique the literature that has used solution-focused (SF) approaches in ID, and consider future directions. **Methods:** A literature review was carried out, identifying 12 studies; six with individuals, and six with staff and families. **Results:** There is preliminary evidence for the effectiveness of SFBT for individuals with mild ID and Solution Focused Coaching or Consultation (SFC) for staff working with individuals with moderate and severe ID. However, the current evidence-base consists primarily of case studies. Recommended adaptations include shortened scales and more concrete approaches to eliciting exception-seeking

Conclusions: Solution-focused techniques should be modified to accommodate the cognitive abilities of people with ID and carers should be involved in sessions where possible. There is a need for further controlled studies, with valid and reliable outcome measures, larger samples and longitudinal data.

Keywords: *Intellectual disabilities, psychological interventions, solution-focused*

Solution-Focused Approaches in an Intellectual Disabilities Context: A Critical Review

Introduction

Psychological difficulties and people with intellectual disabilities

There is evidence to suggest that people with Intellectual disabilities (IDs) have an increased risk of mental health difficulties due to both genetic vulnerability (Vereenoghe & Langdon, 2013) and increased risk of adverse life events (Martorell et al., 2009; Vereenoghe & Langdon, 2013; Wigham, Taylor, & Hatton, 2014). Prevalence rates of mental health difficulties in this population range from 10% to 40.9% (Cooper, S. A., Smiley, E., Finlayson, J., Jackson, A., Allan, L., Williamson, A. and Morrison, J., 2007a; Cooper, Smiley, Morrison, Williamson, & Allan, 2007b; Emerson et al., 2012; Singleton, Bumpstead, O'Brien, Lee, & Meltzer, 2001), with variation in estimates attributed to a lack of robust methodologies and inconsistent definitions within existing studies (Cooper et al., 2007a). Additionally, 10-15% of people with IDs are reported to have behaviour that challenges (e.g. aggression towards others, destruction, self-injury) (Cooper et al., 2009a; Cooper et al., 2009b; Emerson et al., 2012; Lowe et al., 2007). It is clear therefore that the evidence-based treatment of mental health and behavioural difficulties in people with ID represents a significant priority.

Recent meta-analyses have demonstrated that people with ID, mostly within the mild range, can benefit from psychological therapy (Nicoll, Beail, & Saxon, 2013; Prout & Nowak-Drabik, 2003; Vereenoghe & Langdon, 2013). This evidence base is strongest for Cognitive Behavioural Therapy (CBT) for anger and depression (Nicoll et al., 2013; Vereenoghe & Langdon, 2013). In these studies, the protocols that were originally developed for the general population were often modified to accommodate for the cognitive abilities of people with IDs, as per the guidance from the Royal College of Psychiatrists (2004). The guidance also emphasizes that therapists should be

creative and flexible in tailoring techniques to individuals with IDs (Royal College of Psychiatrists, 2004). Additionally, studies have highlighted the benefits of involving carers in sessions to aid communication and outside of sessions to reinforce lessons learned in therapy (Willner, 2005). Whilst protocol modifications such as these can benefit people with mild IDs, it is unclear whether protocols can be sufficiently adapted for people with more significant impairments in intellectual functioning (Campbell, Robertson, & Jahoda, 2014).

In comparison to the general population there remains paucity in the evidence base for psychological therapies for people with IDs (Bhaumik, Gangadharan, Hiremath, & Russell, 2011; Hastings, 2013; Vereenoghe & Langdon, 2013; Willner, 2005). Oliver et al. (2002) acknowledge that there are a number of obstacles to conducting Randomised Control Trials (RCTs) with people with IDs: difficulties obtaining informed consent from individuals and when appropriate their carers; having a smaller client base to recruit from; offering Care As Usual (CAU) being perceived as inappropriate.

However, whilst RCTs help to establish efficacy, they are not always the most appropriate choice of design in psychological intervention studies. Recruitment into RCTs may in itself result in a skewed population, and in providing statistically significant sample sizes they may not provide the detail regarding which patients will benefit from the treatment (Clay, 2010). Other studies can therefore be valuable in providing information regarding “the translation of evidence-base to everyday clinical practice” (Campbell et al, 2014).

Solution-Focused (SF) approaches

Over the last twenty years, Solution-Focused Brief Therapy (SFBT) has gained popularity as a psychological approach in the general population (Gingerich & Peterson, 2012). It is a short-term (generally six sessions), goal-focused and client-directed approach, originally developed by de Shazer and colleagues (1985; 1986; 2007). The central assumption of SFBT is that therapy should

support a client to reach his or her goals by constructing solutions rather than analysing problems (Beyebach, 2000; De Shazer et al., 1986, 2007; Gingerich & Eisengart, 2000; Trepper et al., 2012). Other core assumptions include: there will be exceptions when the problem is absent or reduced; clients have the strengths and resources to change; and interactions between the clinician and client should be collaborative. SFBT draws from a range of techniques, which are outlined in Table 1 (Beyebach, 2000; De Shazer et al., 1986, 2007; Gingerich & Eisengart, 2000; Trepper et al., 2012).

[Insert table 1]

SFBT has an emerging evidence-base in the general population, across a variety of settings: mental health care, social care, criminal delinquency, occupational rehabilitation and health management (Gingerich & Peterson, 2012; Kim, 2007). It has been used with adults, children, couples, families, groups and organisations (Corcoran & Pillai, 2009; Gingerich & Peterson, 2012; Kim, 2007; Stams, Dekovic, Buist, & de Vries, 2006). Meta-analyses have found SFBT to be an effective intervention for a range of presentations including depression, anxiety, self-harm, obsessive-compulsive disorder, posttraumatic stress disorder and relationship conflict (Corcoran & Pillai, 2009; Gingerich & Peterson, 2012; Kim, 2007; Stams, Dekovic, Buist, & de Vries, 2006). A recent meta-analysis found that in 32 of 43 controlled outcome studies there had been a statistically significant benefit of SFBT and a further 10 indicated positive trends (Gingerich & Peterson, 2012). The strongest evidence was for adults with depression (Gingerich & Peterson, 2012). SFBT has also been found to have larger effects when the problems are behavioural rather than interpersonal or mental health related (Stams et al., 2006). Although there is growing evidence to support SFBT, there are also important limitations and critiques to consider. Primarily, it has been argued that focusing on solutions may result in a lack of acknowledgement and exploration of wider difficulties and context (Thomas, 2007), which in turn may create or perpetuate problems in the longer term. The focus on the unique experience of the individual may also result in less acknowledgement of factors that may connect individuals such as race, ethnicity gender and age. In addition, the focus on change may result in either the client or therapist feeling rushed to see this process and biased reporting of

successful outcomes (Thomas, 2007). However, proponents of SFBT might argue that an awareness of this in practice can support the approach being applied appropriately.

SF approaches for people with ID

Several authors have recognised the possible benefits of SF approaches in the context of ID (Bliss, 2005; Roeden et al., 2009; Smith, 2005; Stoddart, McDonnell, Temple, & Mustata, 2001). Its focus on strengths, competencies and empowerment is advantageous, as people with ID may commonly have the opposite experiences of deficiency and disempowerment (Roeden et al., 2009). Additionally, SFBT has been effectively used for a range of problems in the general population that people with ID also present with (Gingerich & Peterson, 2012). In particular, indications that behavioural problems respond well to SFBT is of interest to this population (Stams et al., 2006).

In addition to individual SFBT, Solution Focused Coaching or Consultation (SFC) focusses on the staff's goal for working with an individual with ID and the competencies staff have to achieve their goals (Roeden et al., 2012). Thus, another advantage of a SF approach in ID might be that people with lower functioning can benefit through the work of their carers and family. In summary, over the last twenty years, SFBT approaches have grown in popularity, and there are clear potential benefits of SF approaches in ID. Whilst this approach may show promise with people with ID it is also recognised that adaptations are generally needed to any therapeutic approach when applied to this population, particularly in relation to simplifying language and process, augmenting techniques with more visual methods, consideration of developmental level, being more directive and increased involvement of carers (Hurley, Tomasulo and Pfadt, 1998). It is therefore crucial to consider both the outcomes and the adaptations to SFBT interventions within the context of people with ID. However, to the authors' knowledge there is yet to be a review of the current evidence-base in this population.

Aims

The aims of the current review are to:

- Summarise and critically review the literature that has applied SF approaches in the context of ID.
- Provide an overview of the research quality of the identified studies and consider the research implications.
- Outline how SF approaches were adapted and applied, and discuss clinical implications.

Method

Search strategy

A search was conducted incorporating research published between January 1990 and February 2016. The search terms are outlined in Table 2.

[Insert Table 2]

Inclusion/Exclusion Criteria.

Studies were considered appropriate for inclusion based on the following:

- They were intervention studies that met the criteria for a solution-focused approach by using one or more technique described in Table 1
- The population included in the study met the criteria for global significant intellectual impairment required for an ID diagnosis (APA, 2013; WHO, 1992)

Studies were excluded if:

- The population included had a diagnosis of a specific learning difficulty (e.g. dyslexia, dyspraxia, attention deficit disorder)
- They weren't original research papers (e.g. review papers)

Review Process

The study search terms (Table 2) were entered into the PsychNET database, yielding 163 results, and Web of Science database, with 42 results. Two further articles were identified through manual searching of the reference lists of the articles identified and Google Scholar searches of other research that had cited the articles identified. In total, 26 duplicates were removed.

A total of 181 results were screened. The titles and abstracts were read by the first author and 157 results were excluded. Full-texts were obtained for the remaining 24 articles. They were reviewed thoroughly by the first author and subsequently discussed with the second author to ensure they met the review's eligibility criteria, resulting in 12 being excluded. Reasons for exclusion at this stage were that the study did not include one or more of the techniques outlined in Table 1 (n=3), was not published in English (n=3), was not conducted with people with ID or insufficient information was provided to determine the presence of an ID (n=3), was not an original research article (n=2), or investigated questionnaire validity or methods of evaluating SF (n=1). A final number of 12 articles were included in the review (See Fig. 1)

[Insert Figure 1]

Data Extraction and analysis

Data was extracted from each of the articles, and then summarised. Separate tables are used for SFBT for individuals with ID (see Table 3) and SFC for staff and families (see Table 4). (Please note in Lloyd & Dallos's 2006 & 2008 studies, they describe SFBT for families. As this did not predominantly involve direct work with individuals with IDs it has been included under SFC). A synthesis and critical appraisal of research quality is provided in the text. The Centre for Evidence-Based Management's (Phillips et al., 2009) checklist for critical appraisal of cases studies was used as the majority of the literature in this area adopted a case study design. The checklist was used to assess descriptive quality and transferability of the studies, as well as robustness of the

methodology (i.e. design, method and analysis). Study quality was categorised as follows: poor, acceptable, good and very good.

[Insert Table 3]

[Insert Table 4]

Results

Description of studies

Design. The most commonly used design was single case design (n=4; Bliss, 2005; Murphy & Davis, 2005; Rhodes, 2000; Smith, 2005), followed by qualitative studies (n=3; Lloyd & Dallos, 2006, 2008; Smith, 2011), case series (n=2; Roeden, Maaskant, Bannink, & Curfs, 2011; Roeden et al., 2012), controlled studies (n=2; Roeden, Maaskant, & Curfs, 2014a; Roeden et al., 2014b) and lastly a descriptive service evaluation (n=1; Stoddart et al., 2001). Sample sizes were relatively low as would be expected given the predominance of single case design, therefore limiting generalisability. Oliver et al. (2002) acknowledge however, that in ID service settings there is a restricted client base to recruit from and this is a plausible reason for smaller numbers when compared with similar research conducted by mainstream services.

Setting. Of the 12 studies identified, six were from the United Kingdom (UK), four from the Netherlands, and one each from Canada and the United States (US). (Please note Lloyd & Dallos' studies (2006, 2008) used the same set of families and hence setting and participant details are only reported once). Studies were completed in community ID teams, offering psychological (n= 4) and social services (n= 1) on an outpatient basis, in residential and day care settings (n=5) and in a residential school (n=1). Many ID services are multidisciplinary and clients in these studies are likely to have received other input, in addition to SF approaches (McParland, 2015). However, only Stoddart et al. (2001) stated that participants did not receive any other input.

ID screening. Most SFBT studies reported the ID ranges of clients but did not specify how this was determined. Studies were conducted with people in the borderline range (n=4); mild range (n=4); mild/moderate range (n=1); and moderate range (n=1). Stoddart et al. (2001) state that diagnosis is based on Diagnostic and Statistical Manual of Mental Disorders (4th Edition) as a criterion for accessing the service. Roeden et al. (2011, 2014a) reported instruments used to determine ID diagnosis. Most SFC studies only stated general ID ranges (moderate, severe and profound) but not the screening procedures used. The BPS (2015) acknowledges that it is not uncommon for ID services to make decisions regarding ID ranges based on clients' histories and their and their carers'/families' reports of functioning. However, it strongly recommends that standardised instruments also be administered to assess IQ and adaptive functioning. Unfortunately, the general lack of information regarding ID diagnoses in the identified studies impacts external validity.

Demographics. Gender was generally reported in the SFBT studies, with both males (n=11) and females (n=18) represented. Unfortunately, of the studies with the most robust methodologies, two did not investigate the impact of gender on outcomes (Stoddart et al., 2001; Roeden et al. 2011) and one did not report gender breakdown (Roeden et al., 2014). People with IDs across the lifespan (9-60 years old) were included, suggesting potential utility across age and life stages. However, only Murphy & Davis (2005) used SFBT with a child (9 years old). While this case study had a reasonably strong design (reliable measurements at pre, post and follow-up), further studies are required to determine effectiveness. In SFC studies, the gender and ages of clients that care staff were working with was rarely reported. Care staff and families receiving SF approaches were predominantly female. Across the studies, reporting of ethnicity and socio-economic status was variable, which unfortunately reduced generalisability and consideration of these factors within the context of the intervention.

Studies used a range of measurement tools. Positive qualitative feedback and descriptive outcomes were consistently reported in studies using single case designs (e.g. Bliss, 2005; Smith, 2005). The SF technique of scaling was also utilised and could be considered an idiosyncratic self-report measure (e.g. Rhodes, 2000). However, pre-post differences in scaling scores were rarely reported and when they were reported it was not in a results section, making it difficult for the reader to identify the information. The only studies to use standardised measures were Roeden et al (2011, 2012, 2014a, 2014b) and Stoddart et al. (2001) who included measures such as quality of life and satisfaction with the intervention.

Main findings

SFBT Delivery. SFBT was only provided to clients with mild and moderate ID and studies consistently found it was effective in addressing a range of problems for this client group. In particular, Roeden et al.'s (2011, 2014a) studies, which had the strongest methodologies (with standardised screening measures, valid and reliable measures and a pre, post and follow-up design) found SFBT was effective in reducing problems in alcohol use, sleep, depression, anxiety, self-esteem and relationship difficulties. In addition, Stoddart et al. (2001) found participants with IDs who self-referred, had fewer presenting problems, and whose problems were around poor self-esteem, family relationships and bereavement performed better on clinician ratings of success post-SFBT. Those with depression, anxiety, couples conflict and independence issues were the least successful, but in other studies SFBT was considered helpful in addressing these problems. None of the studies offered SFBT to individuals requiring psychological input for severe mental health problems (e.g. schizophrenia, bi-polar disorder), risk to self and others, and abuse or trauma work.

In SFBT, clients received between five to eleven sessions. Whilst a chief characteristic of SFBT is that it is “brief” (normally six sessions), some studies (Bliss, 2005; Roeden et al., 2011; Stoddart et al., 2001) suggested that individuals with ID benefit from additional sessions. Similar

recommendations for other psychological approaches for people with ID have been made in the literature (Campbell et al., 2014).

The average number of techniques used per study was six (range: 2-10). Few studies used specific SFBT treatment protocols. The exceptions were Roeden et al. (2012, 2014a), who stated that they used a consistent format for each session that primarily adhered to the standard SFBT protocol developed by De Shazer et al. (2007). Smith (2005) found that using fewer techniques was less “confusing” for clients with IDs. In addition, Murphy & Davis (2005) exclusively used video feedback as means of exploring exceptions and self-modelling desired behaviour. This stands out as a resourceful method to engage a client with moderate ID and limited expressive language. The most commonly used techniques were: scaling (n=5); exception seeking (n= 5); compliments (n=4); competency questions (n=4); and hypothetical future (n=4). There is a degree of overlap between the different techniques and for this reason it is possible that some studies used other techniques but did not explicitly stated this. As would be expected, additional adaptations were made for individuals with ID that were not made for care staff and families in SFC; for the most part these were consistent with regular recommendations for adapting psychological therapies for people with IDs (Royal College of Psychiatrists, 2004).

Firstly, clients with ID were supported by a carer or family member during and in-between sessions (Bliss, 2005; Roeden et al., 2011, 2014a; Smith, 2005; Stoddart et al., 2001). Carers and family members could remind clients about inter-session tasks and aid completion and helped clients to understand and respond to questions asked by the therapists. Stoddart et al. (2001) found that clients who were supported by carers in and between sessions had significantly better outcomes (clinician ratings of therapy success). Secondly, scales were adapted: using shorter scales (2- or 3-points); using pictorial scales; having scales on a vertical axis rather than horizontal axis; using concrete examples (thermometer); and basing scales on specific behaviours (Bliss, 2005; Stoddart et al.,

2001). Thirdly, adaptations to exception seeking were suggested. These included using role-play, videotalk and actual videos to make exception seeking more concrete for clients (e.g. Murphy & Davis, 2005; Smith, 2005). Fourthly, the importance of helping clients to structure responses to competency questions was emphasised. Bliss (2005) described how additional structuring to questions by giving several options aided responses. Lastly, the most common technique requiring adaptation was the “miracle question”, regardless of whether it was for clients with IDs, their family or their carers. This technique involves posing a scenario to the client whereby a miracle happens when they are asleep one night and the ‘problem’ they are experiencing is solved. They are then asked what they will notice when they wake up to indicate that the problem has gone (De Shazer, 1988). In Stoddart et al.'s study (2001) individuals with ID clients were asked “what their wish for therapy was, what their wishes for their life were, or how they would know therapy was finished” and in Roeden et al. (2014a; 2014b), they asked carers to consider “when you look forward and things have improved, what will you be doing differently?” Interestingly, there was an exception to this, Lloyd & Dallos (2006) observed that in sessions with mothers of children with IDs, the ‘miracle question’ prompted a shift from wishful thinking to problem-solving. However, in a follow-up study the mothers reported that the ‘miracle question’ was the least helpful aspect of therapy (Lloyd & Dallos, 2008). Hence, Lloyd & Dallos subsequently recommended that the question be re-worded.

Dropout was generally low, implying that the intervention is well received and accepted by clients with mild to moderate IDs. However, in Stoddart et al.'s (2001) study 29 clients were initially referred to SFBT. Of these, 13 did not complete therapy: five withdrew their request for therapy, five were re-directed to long-term therapy, two dropped out after one to two sessions and one had not yet completed therapy. Two of those who did not complete therapy were the only clients with moderate ID in this study. Two people dropped out of Roeden et al.'s (2014a) study for the following reasons: lack of trust in the treatment; dissatisfaction with the therapeutic relationship; pressures from family or others to withdraw; and treatment was not a personal choice. Furthermore,

in one SFC study, a child with ID and autism attending the family session was reported to struggle with SF concepts due to poor understanding of the future, difficulties differentiating between fantasy and realities and difficulties focusing on the whole rather than details (Dallos & Lloyds, 2006). These examples raise questions regarding the appropriateness of directly using SF approaches for some individuals with ID.

SFC delivery. When SFC was provided it was always for care staff working with clients with moderate, severe and profound ID. In the identified studies care staff received between three and four sessions. In comparison to SFBT, in SFC a larger number of techniques were used (range: 7-10), which is consistent with standard SFBT protocol developed for the general population (De Shazer et al., 2007) and as noted above adaptations to the techniques used was not required for staff. Care staff self-referred to SFC if they had support-related problems and families were either clinician- or self-referred for a variety of reasons. The most common referral reason was related to challenging behaviour, with studies consistently reporting that SFC was helpful in addressing these issues. For example, Roeden et al. (2014b) found that SFC was superior to CAU at post-treatment and at follow-up.

Smith (2011) was the only SFC study to highlight difficulties applying the solution-focused approach in the context of ID. Social work staff were provided with a two-day workshop on use of SF approaches with individuals with ID. Unlike the other studies using SFC, this meant there was not a focus on a particular client and this perhaps contributed to their reported difficulty implementing the techniques. In comparison, care staff and families from the other studies assessed the SF approach and techniques favourably (Rhodes, 2000; Roeden et al., 2012; 2014b).

Rhodes (2000) highlighted another advantage of SFC was that it was a good starting point that could then be integrated with other approaches. This is important given that most ID services are

multidisciplinary and clients will likely receive different inputs, aside from SFC (McParland, 2015). However, because of this it is not clear whether SFC alone is a sufficient intervention for care staff experiencing difficulties providing support or whether additional approaches (e.g. behavioural) will be required. For example, Lloyd & Dallos' (2006, 2008) reported only their initial SFC session. The authors state that some families went on to have further SF input or other input; the details of what this entailed were not reported. Hence, it is not clear whether SFC alone is a sufficient intervention for care staff experiencing difficulties providing support or whether additional approaches (e.g. behavioural) will be required.

Fidelity The level of experience of SF practitioners in the studies varied; some had informal experience and some had formal training. Almost all studies actively sought to encompass the core assumptions and techniques of SF, suggesting there were attempts to ensure treatment fidelity, although no formal evaluation of this was reported.

Summary of Methodological Limitations

A number of recurring limitations were noted within the papers reviewed here. The reliance on single case designs and small-scale research resulted in a lack of baseline and follow-up measurement, control groups and randomisation, which limits the generalisability and reliability of results (Bhaumik et al., 2011; Hastings, 2013; Vereenoghe & Langdon, 2013; Willner, 2005). In addition, seven out of the twelve studies did not use standardised outcome measures.

Limited demographic detail was provided, particularly in relation to establishing level of ID, and demographic variables such as gender and age were not considered as part of the analysis.

No study compared to another active treatment, therefore it is possible that the successful outcomes reported in the identified studies could be attributed to non-specific therapy factors (the client-therapist relationship) rather than specific factors (SF approach and techniques). It should also be noted that due to publication bias it is unlikely that studies in this review, especially those with a

single case-design, would have been published had they not obtained positive outcomes. Thus, there is a possibility that effectiveness of SF approaches for people with IDs has been overestimated.

Discussion

This review has aimed to provide an overview of the evidence-base for solution-focused approaches within the context of working therapeutically with people with ID. Studies provide preliminary support for the benefits of both individual and staff/family-based SF approaches in the context of ID. Findings were strongest for individuals in the borderline or mild ID ranges. In addition, the evidence for SFC with care staff experiencing problems in their work with clients in the moderate, severe and profound ID ranges was promising.

The identified studies illustrate the benefits of using a SF approach that emphasises clients' and carers' strengths, competencies and empowerment (Roeden et al., 2009). This approach might be especially appropriate within the context of working therapeutically with people with ID, where experiences of deficiency and disempowerment are often a strong narrative for clients and staff (Bliss, 2005; Roeden et al., 2012). In addition, several studies note that SFBT benefits from a structured and concrete approach, which may also be of benefit to many people with ID (Stoddart et al, 2001; Roeden et al., 2011). From a service perspective, SF approaches may offer healthcare professionals working with people with ID an attractive and economical intervention that allows more timely outcomes.

Studies in this review found SFBT to be effective across a variety of presenting difficulties including substance misuse, depression, anxiety and relationship difficulties. SFC was also found to be effective, mostly within the context of addressing behavioural difficulties. These findings warrant further investigation, particularly given that behavioural difficulties alone have been found

to account for a significant proportion of mental health difficulties in people with ID (Cooper et al, 2007).

Although positive outcomes were found within the studies reviewed, they also indicated that standard SFBT may require modification in order to prove a successful intervention for people with ID. Adaptations such as involvement of carers or family members, use of fewer techniques and adaptations to techniques including simplified language, using concrete examples and using smaller 2-point scales and pictorial scales were all recommended. These are consistent with general guidance on adapting psychological techniques to accommodate for the cognitive abilities of people with IDs (Roeden et al., 2009; Royal College of Psychiatrists, 2004). In addition, it was recommended that the wording of the “miracle question” regarding hypothetical future be re-phrased. The idea of a “miracle” may have been considered unhelpful because it seemed irrelevant in the context of ID or primed participants towards “wishful thinking” around the ID being absent or removed (Lloyd & Dallos, 2008). This poses the danger of locating problems within the individual and the disability, rather than seeing the potential for realistic change. However, there were some responses to the question that were considered positive, such as prompting discussion regarding greater understanding and acceptance. It was generally suggested that the question be re-phrased so that it was more concrete and more focused on coping, strengths and competencies.

Most of the limitations of SFBT and SFC for this client group can currently be attributed to the limited evidence base. In comparison to the general population there remains paucity in the evidence base for psychological therapies for people with IDs (Bhaumik, Gangadharan, Hiremath, & Russell, 2011; Hastings, 2013; Vereenoghe & Langdon, 2013; Willner, 2005), and it is acknowledged that there are a number of obstacles to conducting Randomised Control Trials (RCTs) with people with IDs, such as difficulties obtaining informed consent from individuals and when appropriate their carers; having a smaller client base to recruit from, and offering Care As

Usual (CAU) being perceived as inappropriate (Oliver et al, 2002). In addition, whilst RCTs help to establish efficacy, they are not always the most appropriate choice of design in psychological intervention studies. Recruitment into RCTs may in itself result in a skewed population, and in providing statistically significant sample sizes they may not provide the detail regarding which patients will benefit from the treatment (Clay, 2010). Other studies can therefore be valuable in providing information regarding “the translation of evidence-base to everyday clinical practice” (Campbell et al, 2014).

Nevertheless, the reliance on case studies and the lack of robust methodology within the current review limits the conclusions that can be drawn regarding the efficacy of solution-focused approaches. There remains a need for further controlled studies, with larger samples and longer follow-ups. To establish efficacy, RCTs with full randomisation to SF interventions with specific treatment protocols (e.g. Roeden et al., 2011, 2014b), and CAU or another active intervention are warranted. Studies should also use several different measures (descriptive, idiosyncratic and standardised) simultaneously, allowing for assessment of changes in client-centred goals, as well as broader evaluation of psychological outcomes across the evidence-base (McParland, 2015).

Generalisability of findings would be improved if further information regarding the assessment of ID ranges and other demographics was reported, and efforts should be made to provide background information about service settings, including any input provided alongside SF interventions. The SF clinicians in these studies varied in terms of their level of experience and training and further guidance is required to enable clinicians to make decisions regarding whether they have the competencies required to offer SF interventions. Finally, although diverse referral reasons suggest broad applicability future research should prioritise samples with more defined populations, allowing for better identification of problem-specific outcomes.

Conclusions

This review has examined the evidence for SF approaches in the context of IDs. Thus far the findings suggest that SF approaches show promise across a range of presenting difficulties. They illustrate a number of potential benefits of a SF approach that focuses on creating solutions rather than analysing problems, and builds on the strengths and competencies of individuals with IDs, their families and their carers. However, the research base remains in its infancy and limits the conclusions that can be drawn about the effectiveness of SF approaches for this population. Further robust research is imminently needed if we want commissioners, service managers and clinicians to integrate SF approaches into their services.

References

- American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders: DSM-5*. (American Psychiatric Association, Ed.) (Fifth edit). Arlington, Va.: American Psychiatric Publishing.
- Appelo, M. T. (2005). *Positieve Uitkomsten Lijst; PUL [Positive Outcome Scale; POS]*. Nijmegen: Cure & Care Publishers.
- Bannink, F. P. (2010). *1001 solution-focused questions*. New York: Norton.
- Beyebach, M. (2000). European brief therapy association outcome study: Research definition description of the treatment. Retrieved April 20, 2015, from <http://www.ebta.nu/page2/page30/page30.html>
- Bhaumik, S., Gangadharan, S., Hiremath, A., & Russell, P. S. S. (2011). Psychological treatments in intellectual disability: The challenges of building a good evidence base. *British Journal of Psychiatry*, 198(6), 428–430. <http://doi.org/10.1192/bjp.bp.110.085084>
- Bliss, E. V. (2005). Common Factors, a Solution Focus and Sarah. *Journal of Systemic Therapies*, 24, 16–31. <http://doi.org/10.1521/jsyt.2005.24.4.16>
- British Psychological Society. (2000). *Learning Disability: Definitions and Contexts*. Leicester.
- British Psychological Society. (2015). *Guidance on the assessment and diagnosis of intellectual disabilities in adulthood: A document compiled by a Working Group of the British Psychological Society's Division of Clinical Psychology, Faculty for People with Intellectual Disabilities*. Leicester.
- Campbell, M., Robertson, A., & Jahoda, A. (2014). Psychological therapies for people with intellectual disabilities: Comments on a Matrix of evidence for interventions in challenging behaviour. *Journal of Intellectual Disability Research*, 58(2), 172–188. <http://doi.org/10.1111/j.1365-2788.2012.01646.x>
- Clay, R. (2010) More than one way to measure. *Monitor on Psychology*, 41(8), 52
- Cooper, S. A., Smiley, E., Allan, L. M., Jackson, A., Finlayson, J., Mantry, D., & Morrison, J.

- (2009). Adults with intellectual disabilities: Prevalence, incidence and remission of self-injurious behaviour, and related factors. *Journal of Intellectual Disability Research*, 53(3), 200–216. <http://doi.org/10.1111/j.1365-2788.2008.01060.x>
- Cooper, S. A., Smiley, E., Finlayson, J., Jackson, A., Allan, L., Williamson, A., Morrison, J. (2007). The prevalence, incidence, and factors predictive of mental ill-health in adults with profound intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 20(6), 493–501. <http://doi.org/10.1111/j.1468-3148.2007.00401.x>
- Cooper, S. A., Smiley, E., Jackson, A., Finlayson, J., Allan, L., Mantry, D., & Morrison, J. (2009). Adults with intellectual disabilities: Prevalence, incidence and remission of aggressive behaviour and related factors. *Journal of Intellectual Disability Research*, 53, 217–232. <http://doi.org/10.1111/j.1365-2788.2008.01127.x>
- Cooper, S.-A., Smiley, E., Morrison, J., Williamson, A., & Allan, L. (2007). Mental ill-health in adults with intellectual disabilities: Prevalence and associated factors. *The British Journal of Psychiatry*, 190, 27–35. <http://doi.org/10.1192/bjp.bp.106.022483>
- Corcoran, J., & Pillai, V. (2009). A review of the research on solution-focused therapy. *British Journal of Social Work*. <http://doi.org/10.1093/bjsw/bcm098>
- De Shazer, S. (1985). *Keys to solution in brief therapy*. New York, NY: Norton.
- De Shazer, S. (1988). *Clues: Investigating solutions in brief therapy*. New York, NY: Norton.
- De Shazer, S., Berg, I. K., Lipchik, E., Nunnally, E., Molnar, A., Gingerich, W., & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. *Family Process*, 25(2), 207–221. <http://doi.org/10.1111/j.1545-5300.1986.00207.x>
- De Shazer, S., Dolan, Y., Korman, H., Trepper, T., McCollum, E., & Berg, I. (2007). *More than miracles: The state of the art of solution-focused brief therapy*. New York, NY: Haworth Press.
- Department of Health. (2001). *Valuing People: A New Strategy for Learning Disability for the 21st Century* (Vol. March).

- Emerson, E., Hatton, C., Robertson, J., Roberts, H., Baines, S., Evison, F., & Glover, G. (2012). *People with Learning Disabilities in England 2011*.
- Gingerich, W. J., & Eisengart, S. (2000). Solution-Focused Brief Therapy: A review of the outcome research. *Family Process*, 39(4), 477–498. <http://doi.org/10.1111/j.1545-5300.2000.39408.x>
- Gingerich, W., & Peterson, L. (2012). Effectiveness of Solution-Focused Brief Therapy: A Systematic Qualitative Review of Controlled Outcome Studies. *Research on Social Work Practice*, 0(3), 1–18. <http://doi.org/10.1177/1049731512470859>
- Hastings, R. P. (2013). Running to catch up: Rapid generation of evidence for interventions in learning disability services. *British Journal of Psychiatry*, 203(4), 245–246. <http://doi.org/10.1192/bjp.bp.113.127605>
- Hoekman, J., Douma, J. C. H., Kersten, M. C. O., Schurman, M. I. ., & Koopman, H. M. (2001). IDQOL- Intellectual Disability Quality of Life: de ontwikkeling van een instrument ter bepaling van de “kwaliteit van bestaan” van mensen een verstandelijke handicap [Developing an instrument to determine the “quality of life” for people with intellectual. *Nederlands Tijdschrift Voor de Zorg Aan Verstandelijk Gehandicapten (NTZ) [Dutch Journal for the Care of People with Intellectual Disabilities]*, 27, 207–225.
- Hurley A., Tomasulo D. J. & Pfadt A. G. (1998) *Individual and group psychotherapy approaches for persons with intellectual disabilities and developmental disabilities*. *Journal of Developmental and Physical Disabilities* 10, 365–386.
- Kim, J. S. (2007). Examining the Effectiveness of Solution-Focused Brief Therapy: A Meta-Analysis. *Research on Social Work Practice*, 18(2), 107–116. <http://doi.org/10.1177/1049731507307807>
- Koomen, H., Verschueren, K., & Pianta, R. (2007). *Leerling leerkracht relatie vragenlijst [student teacher relationship scale]*. Houten: Bohn Stafleu van Loghum.
- Kraijer, D. W., & Kema, G. N. (1994). *Sociale redzaamheidsschaal, SRZ-p voor zwakzinnigen van hoger niveau. Handleiding [Manual for the SRZ social skills scale for people with mild*

intellectual disabilities]. Lisse, the Netherlands: Swets Test Service.

Llewelyn, S. P. (1988). Psychological therapy as viewed by clients and therapists. *The British Journal of Clinical Psychology*, 27 (Pt 3), 223–237. <http://doi.org/10.1111/j.2044-8260.1988.tb00779.x>

Lloyd, H., & Dallos, R. (2006). Solution-focused Brief Therapy with Families Who Have a Child with Intellectual Disabilities: A Description of the Content of Initial Sessions and the Processes. *Clinical Child Psychology and Psychiatry*, 11, 367–386. <http://doi.org/10.1177/1359104506064982>

Lloyd, H., & Dallos, R. (2008). First session solution-focused brief therapy with families who have a child with severe intellectual disabilities: Mothers' experiences and views. *Journal of Family Therapy*, 30, 5–28. <http://doi.org/10.1111/j.1467-6427.2008.00413.x>

Lowe, K., Allen, D., Jones, E., Brophy, S., Moore, K., & James, W. (2007). Challenging behaviours: Prevalence and topographies. *Journal of Intellectual Disability Research*, 51(8), 625–636. <http://doi.org/10.1111/j.1365-2788.2006.00948.x>

Martorell, A., Tsakanikos, E., Pereda, A., Gutierrez-Recacha, P., Bouras, N., & Ayuso-Mateos, J. L. (2009). Mental health in adults with mild and moderate intellectual disabilities. *The Journal of Nervous and Mental Disease*, 197(3), 182–186. <http://doi.org/10.1097/NMD.0b013e3181923c8c>

McParland, J. (2015). Narrative therapy in a learning disability context: A review. *TIZARD Learning Disability Review*, 20, 121–129.

Miller, S., Hubble, M. A., & Duncan, B. L. (1996). *The handbook of solution-focused brief therapy* (Eds.). San Francisco: Jossey-Bass.

Moher, D., Liberati, A., Tetzlaff, J., & Altman, D. G. (2009). Preferred reporting items for systematic reviews and meta-analyses: The PRISMA statement. *Physical Therapy*, 89(9), 873–880. <http://doi.org/10.1136/bmj.b2535>

Murphy, J. J., & Davis, M. W. (2005). Video Exceptions: An Empirical Case Study Involving a

Child with Developmental Disabilities. *Journal of Systemic Therapies*, 24, 66–79.

<http://doi.org/10.1521/jsyt.2005.24.4.66>

National Institute for Health & Clinical Excellence. (2015). *Challenging Behaviour and Learning Disabilities: Prevention and interventions for people with learning disabilities whose behaviour challenges. NICE guideline 11*. Retrieved from <http://guidance.nice.org.uk/CG/Wave0/654>

Nguyen, T. D., Attkisson, C. C., & Stegner, B. L. (1983). Assessment of patient satisfaction: Development and refinement of a service evaluation questionnaire. *Evaluation and Program Planning*, 6(3-4), 299–313. [http://doi.org/10.1016/0149-7189\(83\)90010-1](http://doi.org/10.1016/0149-7189(83)90010-1)

Nicoll, M., Beail, N., & Saxon, D. (2013). Cognitive behavioural treatment for anger in adults with intellectual disabilities: A systematic review and meta-analysis. *Journal of Applied Research in Intellectual Disabilities*, 26(1), 47–62. <http://doi.org/http://dx.doi.org/10.1111/jar.12013>

Oliver, P. C., Piachaud, J., Done, J., Regan, A., Cooray, S., & Tyrer, P. (2002). Difficulties in conducting a randomized controlled trial of health service interventions in intellectual disability: Implications for evidence-based practice. *Journal of Intellectual Disability Research*. <http://doi.org/10.1046/j.1365-2788.2002.00408.x>

Phillips B., Ball, C., Sackett, D., Badenoch, D., Straus, S., Haynes, B. and Dawes, M. (2009) *Oxford Centre for Evidence-Based Medicine – Levels of Evidence* (March 2009) [<http://www.cebm.net/>](http://www.cebm.net/).

Prout, H. T., & Nowak-Drabik, K. M. (2003). Psychotherapy with persons who have mental retardation: An evaluation of effectiveness. *American Journal on Mental Retardation*, 108(2), 82–93. [http://doi.org/10.1352/0895-8017\(2003\)108<0082:PWPWHM>2.0.CO;2](http://doi.org/10.1352/0895-8017(2003)108<0082:PWPWHM>2.0.CO;2)

Reiss, S., Minnen, A., & Van Hoogduin, K. (1994). *Handleiding; de Nederlandse versie van de Reiss Screen for Maladaptive Behavior [Dutch Manual of the Reiss Screen for Maladaptive Behavior]*. Orland Park: International Diagnostic Systems.

Rhodes, J. (2000). Solution-focused consultation in a residential setting. *Clinical Psychology*

Forum, 141, 29–33.

- Roeden, J. M., Bannink, F. P., Maaskant, M. A., & Curfs, L. M. G. (2009). Solution-focused brief therapy with persons with intellectual disabilities. *Journal of Policy and Practice in Intellectual Disabilities*, 6, 253–259. <http://doi.org/10.1111/j.1741-1130.2009.00226.x>
- Roeden, J. M., Maaskant, M. A., Bannink, F. P., & Curfs, L. M. G. (2011). Solution-focused brief therapy with people with mild intellectual disabilities: A case series. *Journal of Policy and Practice in Intellectual Disabilities*, 8, 247–255. <http://doi.org/10.1111/j.1741-1130.2011.00317.x>
- Roeden, J. M., Maaskant, M. A., Bannink, F. P., & Curfs, L. M. G. (2012). Solution-focused coaching of staff of people with severe and moderate intellectual disabilities: A case series. *Journal of Policy and Practice in Intellectual Disabilities*, 9, 185–194. <http://doi.org/10.1111/j.1741-1130.2012.00352.x>
- Roeden, J. M., Maaskant, M. A., & Curfs, L. M. G. (2014). Effectiveness of solution-focused coaching of staff of people with intellectual disabilities: A controlled study. *Journal of Systemic Therapies*, 33, 16–34. <http://doi.org/10.1521/jsyt.2014.33.2.16>
- Roeden, J. M., Maaskant, M. A., & Curfs, L. M. G. (2014). Processes and effects of Solution-Focused Brief Therapy in people with intellectual disabilities: A controlled study. *Journal of Intellectual Disability Research*, 58, 307–320. <http://doi.org/10.1111/jir.12038>
- Royal College of Psychiatrists. (2004). *Psychotherapy and learning disabilities. Council report 116*. London.
- Schlosser, R. W. (2004). Goal attainment scaling as a clinical measurement technique in communication disorders: A critical review. *Journal of Communication Disorders*. <http://doi.org/10.1016/j.jcomdis.2003.09.003>
- Singleton, N., Bumpstead, R., O'Brien, M., Lee, A., & Meltzer, H. (2001). *Psychiatric morbidity among adults living in private households, 2000*. London.
- Smith, I. C. (2005). Solution-focused brief therapy with people with learning disabilities: A case

study. *British Journal of Learning Disabilities*, 33, 102–105. <http://doi.org/10.1111/j.1468-3156.2005.00293.x>

- Smith, I. C. (2011). A qualitative investigation into the effects of brief training in solution-focused therapy in a social work team. *Psychology and Psychotherapy: Theory, Research and Practice*, 84, 335–348.
- Stams, G. J., Dekovic, M., Buist, K., & de Vries, L. (2006). Effectiviteit van oplossingsgerichte korte therapie: Een meta-analyse. *Tijdschrift Voor Gedragstherapie*, 39(81-94).
- Stoddart, K. P., McDonnell, J., Temple, V., & Mustata, A. (2001). Is brief better? A modified brief solution-focused therapy approach for adults with a developmental delay. *Journal of Systemic Therapies*, 20, 24–40. <http://doi.org/10.1521/jsyt.20.2.24.23039>
- Thomas, F. N. (2007). Possible limitations, misunderstandings, and misuses of solution-focused brief therapy. In T. S. Nelson & F. N. Thomas (Eds.), *Handbook of solution-focused brief therapy: Clinical applications* (pp. 391–408). Binghamton, NY: Haworth.
- Trepper, T., McCollum, E., De Jong, P., Korman, H., Gingerich, W., & Franklin, C. (2012). *Solution-Focused Brief Therapy treatment manual*. In *Solution-Focused Brief Therapy: A handbook of evidence-based practice* (Eds., pp. 20–36). New York, NY: Oxford University Press.
- Vereenoghe, L., & Langdon, P. E. (2013). Psychological therapies for people with intellectual disabilities: A systematic review and meta-analysis. *Research in Developmental Disabilities*, 34(11), 4085–4102. <http://doi.org/10.1016/j.ridd.2013.08.030>
- Wechsler, D. (2005a). *WAIS-III-NL, Wechsler Intelligence Scale for Adults- III*. Amsterdam: Pearson.
- Wechsler, D. (2005b). *WISC-III-NL, Wechsler Intelligence Scale for Children-III*. Amsterdam: Pearson.
- Wigham, S., Taylor, J. L., & Hatton, C. (2014). A prospective study of the relationship between adverse life events and trauma in adults with mild to moderate intellectual disabilities. *Journal of Intellectual Disability Research*, 58(12), 1131–1140. <http://doi.org/10.1111/jir.12107>

- Willems, A. P. A. M., Embregts, P. J. C. M., Stams, G. J. J. M., & Moonen, X. M. H. (2010). The relation between intrapersonal and interpersonal staff behaviour towards clients with ID and challenging behaviour: A validation study of the staff-client interactive behaviour inventory. *Journal of Intellectual Disability Research*, 54(1), 40–51. <http://doi.org/10.1111/j.1365-2788.2009.01226.x>
- Willner, P. (2005). The effectiveness of psychotherapeutic interventions for people with learning disabilities: A critical overview. *Journal of Intellectual Disability Research*, 49, 73–85. <http://doi.org/10.1111/j.1365-2788.2005.00633.x>
- World Health Organization. (1992). *The ICD-10 Classification of mental and behavioural disorders: Clinical descriptors and diagnostic guidelines*. Geneva: World Health Organization.